ARBOVIRAL INFECTION CASE REPORT FORM

PATIENT INFORMATION

Last Name_____ First Name _____ County_____
Address_____ City _____ Zipcode_____ State_____
Telephone-H (____)_____-_____ W (____)_____-_____ Date of Birth_____/_____/_____ Age_____
Occupation:_____ Race: ☐ White ☐ Black ☐ Am. Indian/Alaskan ☐ Asian ☐ Other
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown Sex: ☐ Male ☐ Female Pregnant: ☐ Yes ☐ No ☐ Unknown
Breast Feeding: ☐ Yes ☐ No ☐ Unknown

CLINICAL INFORMATION

Hospitalized? ☐ Yes ☐ No Hospital Name_____
Street Address_____ City_____ State_____ Zip _____
Medical record # _____ Date of admission____/____/____ Date of discharge/transfer____/_____/____
Date of first symptoms____/____/____ Date of first neurologic symptoms____/____/____
Current Diagnosis: ☐ encephalitis ☐ meningitis ☐ myelitis ☐ fever ☐ other_____
Initial Diagnosis: ☐ encephalitis ☐ meningitis ☐ myelitis ☐ fever ☐ other_____

Fever (≥ 38EC or 100EF)	☐ Yes	☐ No	☐ Unknown	Altered mental status	☐ Yes	☐ No	☐ Unknown
Headache	☐ Yes	☐ No	☐ Unknown	Stiff neck/Meningeal signs	☐ Yes	☐ No	☐ Unknown
Seizures	☐ Yes	☐ No	☐ Unknown	Muscle weakness	☐ Yes	☐ No	☐ Unknown
Altered immune status	☐ Yes	☐ No	☐ Unknown	Previous Flavirus vaccination	☐ Yes	☐ No	☐ Unknown
Rash	☐ Yes	☐ No	☐ Unknown	If yes, describe_____			
Other neurologic signs	☐ Yes	☐ No	☐ Unknown	If yes, describe_____			

Other symptoms (current or 1 month before onset)_____
Outcome ☐ Recovered ☐ Died ☐ Unknown If patient died, date of death _____/_____/_____

LABORATORY INFORMATION / TEST RESULTS

CSF (specify units) Date _____/_____/_____ Abnormal? ☐ Yes ☐ No ☐ Unknown
Glu _____ Prot _____ RBC _____ WBC _____ Diff: Segs _____% Lymphs_____%
Gram stain _____ Culture _____
CBC (specify units) Date _____/_____/_____ WBC _____ Diff: Segs _____% Lymphs _____%
MRI Date _____/_____/_____ Results _____
CT Date _____/_____/_____ Results _____
EEG Date _____/_____/_____ Results _____
Microbiology / serology Results _____

CURRENT TREATMENT

(antiviral or antibacterial) **Type:** _____ **Date started:** _____/_____/_____

RISK FACTOR INFORMATION (during **2 weeks** before onset)

				Location	**Dates**
Travel outside USA?	☐ Yes	☐ No	☐ Unk	_____	_____
Travel outside Virginia?	☐ Yes	☐ No	☐ Unk	_____	_____
Travel outside county of residence?	☐ Yes	☐ No	☐ Unk	_____	_____
Occupational exposure (lab or farm)?	☐ Yes	☐ No	☐ Unk	_____	_____
Animal/bird contact?	☐ Yes	☐ No	☐ Unk	_____	_____

If yes specify species: _____
Blood or organ donor? ☐ Yes ☐ No ☐ Unk **If yes, contact the VDH Office of Epidemiology immediately**
Blood transfusion or organ transplant? ☐ Yes ☐ No ☐ Unk **If yes, contact the VDH Office of Epidemiology immediately**
(during **1 month** before onset)

SPECIMENS BEING SUBMITTED TO LAB FOR TESTING

Has the patient previously tested positive for ☐ WNV ☐ SLE ☐ EEE ☐ LAC. What antibody was detected? ☐ IgM ☐ IgG
What laboratory tested the specimen? _____
Name of Lab _____ CSF ☐ Yes ☐ No If yes, date collected _____/_____/_____ ☐ Initial ☐ Repeat
If no, was a lumbar puncture performed? ☐ Yes ☐ No
Name of Lab _____ Serum ☐ Yes ☐ No If yes, date collected _____/_____/_____ ☐ Initial ☐ Repeat
Name of Lab _____ Other _____ Date collected _____/_____/_____ ☐ Initial ☐ Repeat

PHYSICIAN

Last name _____ First name _____
Work address_____ City _____ State_____ Zip Code _____
Telephone (_____) _____-_____ Pager (_____) _____-_____

SUBMITTER

Name _____
Address _____
_____
_____
Phone (_____) _____-_____ **Date of Report:** _____/_____/_____

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment